DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445234	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLEN OAKS HEALTH AND REHABILITATION	**1101 GLEN OAKS ROAD** **SHELBYVILLE, TN 37160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 09/11/2019 for all previous deficiencies cited on 05/13/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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POC#1	445234	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/13/2019

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GLEN OAKS HEALTH AND REHABILITATION	1101 GLEN OAKS ROAD SHELBYVILLE, TN 37160

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, V (000); IBC, V unprotected No plans available on site Constructed: 1976 Sprinklered: Yes Census: 54 Certified beds: 130 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 05/13/2019. During this Life Safety Survey, Glen Oaks Health and Rehabilitation was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353	Sprinkler System-Maintenance and Testing CFR(s): NFPA 101 SS=D 1. The company was called to fix repairs on 05/24/19. 2. The antifreeze sprinkler loop at the canopy will be replaced by 06/26/19. 2. The Administrator educated the maintenance Director and Assistant continued	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Melissa Anderson — LNHA — 05/29/19

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K 353	Continued From page 1 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the sprinkler system. The findings included: Document review of the sprinkler inspection report dated 08/22/2019 on 05/13/2019 at 11:11 AM, revealed the the antifreeze sprinkler loop at the canopy needed replacement (the facility did not provide documentation that needed repairs were conducted). NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 4.1.4.1 (2011 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 05/13/2019.	K 353	continued 3. The Administrator educated the maintenance Director and Maintenance Director on checking the sprinkler loop at the canopy monthly. This will be added to the TELS program on 05/30/19. 3. The Maintenance Director will present the TELS report to monthly Quality Assurance Performance Improvement Committee consisting of the Administrator Director of Nursing, Medical Director, Social Service Director, Pharmacy Representative, Infection Control Nurse, Staff Development Coordinator, Maintenance Director Medical Records Director times 4 months for further follow up and or recommendations as needed.06/27/19	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility	K 761	Maintenance, Inspection $ Testing Doors CFR(s): NFPA 101 SS=D 1. Corporate Plant and Maintenance will send facility Maintenance Director the correct paperwork on 05/30/2019. Continued	

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K 761	Continued From page 2 maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to ensure fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. The findings included: Document review on 05/13/2019 at 11:30 AM, revealed the fire door inspection conducted in 2018 did not contain all required point of inspection. NFPA 101, 4.6.12 (2012 Edition) NFPA 101, 4.6.12.4 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.3 (2010 Edition) The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 05/13/2019.	K 761	Continued 2. The Administrator educated the Maintenance Director and the Assistant Maintenance Director on inspecting all fire door and contain all required point of inspection by 05/31/2019. 3. The Maintenance Director will present the findings in the monthly Quality Assurance Performance Improvement committee. Members include Administrator, Director of Nursing, Medical Director, Social Service Director, Dietary Manager, Infection Control Nurse, Staff Development Coordinator, Maintenance Director, Medical Records Director times 4 months for further follow up and or recommendations as needed.	06/27/19
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment	K 921	Electrical Equipment-Testing and Maintenance CFR(s): NFPA 101 SS=D Continued	

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K 921	Continued From page 3 (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility to comply with electrical equipment testing and maintenance requirements. The findings included: Document review and interview with the administrator on 05/13/2019 at 11:41 AM, revealed the facility failed to provide policies and protocols for the testing and maintenance of patient-care related electrical equipment. NFPA 99, 10.5.2.1.1 (2012 Edition)	K 921	Continued 1. The facility will establish policies and protocols for the testing and maintenance of patient-care related electrical equipment by 05/28/2019. 2. The Administrator will type up a letter and send to all family members and residents about the requirement for checking electrical equipment by 05/30/2019. 3. The Administrator educated the Maintenance Director, Assistant Maintenance Director, The Admission Coordinator, Social Service Director and The Director of Nursing on making sure all electrical equipment has been tested before it goes to a residents room on 05/28/2019. 4. The Maintenance Director will do audits on resident room equipment weekly times four weeks then monthly times four months then ongoing when new equipment comes in.	

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K 921	Continued From page 4 The Maintenance Director was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 05/13/2019.	K 921	Continued The Maintenance Director will present findings to the Quality Assurance Performance Improvement Committee. Members include Administrator, Director of Nursing, Social Service Director, Dietary Manager, Pharmacy Representative Infection Control Nurse, Medical Records Director, Medical Director, Maintenance Director times four months for further follow up and or recommendations as needed.	06/27/19

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{E 000}	Initial Comments A Emergency Preparedness revisit survey was conducted on 09/11/2019 for all previous deficiencies cited on 05/13/2019. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 05/13/2019. During this Emergency Preparedness Survey, Glen Oaks Health and Rehabilitation was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency	E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483(a)(1)-(2) SS=D 1. The facility had a round table meeting/safety meeting on 05/28/2019 regarding facility emergency preparedness program. 2. Facility round table committee addressed the community and facility based assessments and will update risk assessment on 05/30/19. 3. Administrator educated the round table committee on 05/28/2019 regarding risk hazards. continued	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Anderson | TITLE: LNHA | (X6) DATE: 05/29/19

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E 006	Continued From page 1 events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to complete the risk assessment utilizing an all-hazards approach per the requirements of Federal CFR §483.73. The finding included: Interview on 05/13/2019 at 1:40 PM, revealed the facility's facility based/community based risk assessment for the emergency preparedness program did not utilize an all-hazards approach (the assessment only looked at a few specific hazards). This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 006	continued 4. Administrator will bring the round table committee safety/ emergency preparedness notes to monthly Quality Assurance Performance Improvement committee which consist of Administrator, Director of Nursing, Medical Director, Social Service Director, Maintenance Director, Infection Control Nurse, Staff Development Coordinator Medical Records Coordinator monthly times 4 months for further follow up and or recommendations as needed.	06/27/19
E 015 SS=D	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 015	Subsistence Needs for Staff and Patients CFR(s) 483.73(b)(1) SS=D 1. Facility had a round table/safety committee meeting on 05/28/2019 to discuss emergency preparedness program. continued	

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E 015	Continued From page 2 reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm	E 015	continued 2. The facility round table committee addressed the subsistence needs for staff and patients on 05/28/2019. 3. The Dietary Manager was educated on 05/28/2019 regarding providing food and water in an emergency situation for 75 residents and 50 staff members. 4. Dietary Manager will present plan to monthly Quality Assurance Performance Improvement Committee which includes Administrator, Medical Director, Director of Nursing, Social Service Director, Director of Rehabilitation, Infection Control Nurse, Staff Development Coordinator, Medical Records Coordinator monthly times 4 months for further follow up and or recommendations as needed.	06/27/19

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E 015	Continued From page 3 systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to include all policies and procedures for the subsistence needs of residents and staff in the emergency preparedness program. The findings included: Document review and interviews on 05/13/2019 at 1:45 PM, the facility failed to provide policies and procedures for provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: a. Food, water, medical and pharmaceutical supplies This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 015		
E 020 SS=D	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) SS=D 1. The facility had a round table/ safety committee meeting on 05/28/2019 regarding facility preparedness program. Continued	

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E 020	Continued From page 4 Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to include policies and procedures for sheltering in place in the emergency	E 020	Continued 2. Facility round table committee addressed the evacuation plan for the evacuation of residents, staff and visitors. 3. The round table committee started addressing the evacuation and was educated by Administrator on 05/28/2019. 4. The Administrator will present to the Quality Assurance Performance Improvement Committee which consist of Administrator, Medical Director, Director Of Nursing, Infection Control Nurse, Social Service Director, Staff Development Coordinator, Medical Records Coordinator, Maintenance Director monthly times 4 months for further follow up and or recommendations as needed.	06/27/19

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 020	Continued From page 5 preparedness program. The finding included: Document review and interviewson 05/13/2019 at 1:50 PM, revealed the facility had not developed polices and procedures for the evacutation of the residents, staff, and visitors. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 020		
E 022 SS=D	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for	E 022	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) SS=D 1. The facility had a round table meeting/safety committee meeting on 05/28/2019 regarding facility emergency preparedness program. 2. Facility round table committee addressed the policy and procedure on sheltering residents, staff and visitors. 3. The policy and procedure for evacuation will be educated by a round table committee member continued	

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	445234	A. BUILDING _____ B. WING _____	05/13/2019

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E 022	Continued From page 6 hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on document review and interviews, the facility failed to include policies and procedures for sheltering in place in the emergency preparedness program. The finding included: Document review and interviewson 05/13/2019 at 1:55 PM, revealed the facility had not developed polices and procedures for sheltering the residents, staff, and visitors in place. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 022	continued starting 05/29/19 and to be completed by 06/27/2019. 4. The Administrator will present to the monthly Quality Assurance Performance Improvement committee which consist of Administrator, Medical Director, Director of Nursing, Social Service Director, Maintenance Director, Infection Control Nurse, Staff Development Coordinator, Medical Records Director monthly times 4 months for further follow up and or recommendations as needed.06/27/19	
E 024 SS=D	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) SS=D 1. The facility had a round table meeting/safety committee meeting on 05/28/2019 regarding facility emergency preparedness program. continued	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 024	Continued From page 7 (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for the use of volunteers in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 05/13/2019 at 2:00 PM, revealed the facility had no record of polices and procedures for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This finding was verified by the administrator	E 024	Continued 2. Facility round table committee addressed the use of volunteers during an emergency and utilizing staff that are not working when an emergency occurs. 3. The facility will reach out to the local county Emergency Management Service for assistance with getting in touch with county volunteers in case of emergency by 05/30/19. 4. The facility will update its emergency preparedness manual with information as it comes to the facility. 5. The Administrator will present to the Quality Assurance Performance Improvement committee which includes, Administrator, Director of Nursing, Medical Director, Social Service Director, Maintenance Director, Infection Control Nurse, Medical Records Director, Staff Development Director monthly times 4 months for further follow up and or recommendations as needed.	06/27/19

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E 024	Continued From page 8 during the review of the facility's emergency preparedness program	E 024		
E 025 SS=D	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other	E 025	Arrangement with Other Facilities CFR(s): 483.73(b)(7) SS=D 1. The facility had a round table meeting/safety committee meeting on 05/28/2019. 2. Facility round table committee addressed the policy and procedure of having written agreements with other providers in the event of an emergency on 05/28/19. 3. The round table committee will work on getting written agreements with other providers and have completed by 06/27/19. 4. The Administrator will present to the Quality Assurance Performance Improvement committee which consist of Administrator, Medical Director, Director of Nursing, Medical Records Director, Staff Development Director, Maintenance Director. Social Service Director, Infection Control Nurse times 4 months for further follow up and or recommendations as needed.	06/27/19

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E 025	Continued From page 9 providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop arrangements with other facilities receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. The finding included: Document review and interview on 05/13/2019 at 2:07 PM, the facility did not provide written arrangements with other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 025		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030	Names and Contact Information CFR(s): 483.73(c)(1) SS=D 1. The facility had a round table meeting/safety committee meeting on 05/28/2019. 2. Facility round table committee addressed having names and contact information for staff Continued	

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E 030	Continued From page 10 (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030	Continued and entities with service agreements, patient's physicians, Next of kin, guardian or custodian, other facilities and volunteers. 3. The round table committee will work on getting written agreements with other providers and have completed by 06/27/19. 4. The Administrator will present to the Quality Assurance Performance Improvement committee which consist of Administrator, Medical Director, Director of Nursing, Medical Records Director, Staff Development Director, Maintenance Director. Social Service Director, Infection Control Nurse times 4 months for further follow up and or recommendations as needed.	06/27/19

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E 030	Continued From page 11 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to develop a communication plan that includes contact information. The findings included: Document review on 05/13/2019 at 2:13 PM, revealed the facility did nto have contact information for Entities providing services under arrangement. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 030		
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and	E 035	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) SS=D 1. The facility had a round table meeting/safety committee meeting	

Continued

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E 035	Continued From page 12 updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a communication plan that includes a method for sharing the emergency preparedness plan to residents, families and representatives per CFR 483.73 (c). The findings included: Document review and interview on 05/13/2019 at 2:20 PM, revealed the facility failed to provide methods and procedures for sharing information from the emergency plan with residents and their families or representatives. This finding was verified by the administrator during the interview of the facility's emergency preparedness program.	E 035	Continued on 05/28/2019. 2. The Administrator will write up a communication plan for residents and their family representatives by 06/27/2019. 3. The Administrator will write up a communication plan for the admission packet for future residents by 06/27/2019. 4. The Administrator will present to the Quality Assurance Performance Improvement committee which consist of Administrator, Medical Director, Director of Nursing , Social Service Director, Infection Control Nurse, Maintenance Director, Staff Develop ment Coordinator, Medical Records Director times 4 months for follow up and recommendations as needed.	06/27/19
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must	E 036	EP Training and Testing CFR(s): 483.73(d) SS=D 1The facility had a round table meeting/safety meeting on 05/28/2019. 2. Facility round table committee addressed the training and continued	

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E 036	Continued From page 13 be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include develop and maintain an emergency preparedness training and testing program that is based on the emergency plan in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included:	E 036	Continued and testing and will meet the requirements for evacuation drills and training by 06/27/2019. 2. The staff will participate in our drill and training by 06/27/2019. 3. The round table committee members will educate staff by 06/11/2019. 4. The Administrator will present the results to the Quality Assurance Performance Improvement Committee which includes the Administrator, Director of Nursing, Medical Director, Infection Control Nurse, Social Service Director, Medical Records Director, Staff Development Director, Maintenance Director and Rehab Director and floor staff times four months for further follow up and or recommendations as needed.	06/27/19

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E 036	Continued From page 14 Interview on 05/13/2019 at 2:30 PM, revealed the facility had no record of polices and procedures for the training and testing program that is based on the emergency plan in the emergency preparedness program . This finding was verified by the administrator during the review of the facility's emergency preparedness program	E 036		